INCLUSION OF THE PROPERTY OF THE PARTY OF TH	A MEDICAID SERVICES	_	1#11/00	
	LIVAN PROVIDER/SUPPLIER/CUM	(X2) MULTII	PLE CONSTRUCTION a cupt (X3) DATES	ETED
F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	6 fitty out	c
	005070	B. WING _		06/2006
	295079	STE	FET ADDRESS, CITY, STATE, ZIP CODE	
		2	01 KOONTZ LANE	
REEN MOUNTAINVIE	W HEALTH			(X5)
SUMMARY STA	ATEMENT OF DEFICIENCIES	ID DDGEIY	I PAGE CORRECTIVE ACTION SHOULD BE	COMPLETION
I SECONDICATE OF THE SECONDICATE	MILET BE PRELEEDED DI 1 VEC	TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
INITIAL COMMEN	TS	F 000		
the result of a con at your facility on S finalized on 10/6/0 was sent under se The findings and o by the Health Divis prohibiting any cri claims for relief th under applicable f	conclusions of any investigation shall not be construed as minal or civil actions or other at may be available to any party ederal, state or local laws.	!	REPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE THE PROVIDER'S ADMISSION OF OR AGREEMENT WITH THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF	
2. Provide enoug	stantiated. h staff to accommodate the			
Tags F 246 and F 2. Send a reside discharged - subsideficiencies cited 3. Prevent an av	5 325. nt's personal belongings when stantiated with no federal			
A Rathe a reside	ent for five days and discharge clean condition -			
identified:		E 24	6	
16 483.15(e)(1) AC	COMODATION OF NEEDS	·	TITLE	(X6) DATE
ORY DIRECTOR'S OF PRO	OVIDER/SUPPLIER REPRESENTATIVE'S SIG	314/1 01/12	RON PETERSEN	10-31-06
the date of survey whether	protection to the patients. (See instruction or not a plan of correction is provided. Imments are made available to the facility.	hich the insti ons.) Except For nursing If deficiencie	tution have excused from correcting providing it is of for nursing homes, the findings stated above are disconnection are	determined that closable 90 days disclosable 14 e to continued
	RS FOR MEDICARE TOF DEFICIENCIES TO DEFICIENCIES TO CORRECTION ROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR I INITIAL COMMEN This Statement of the result of a con at your facility on 9 finalized on 10/6/0 was sent under se The findings and of by the Health Divis prohibiting any crit claims for relief the under applicable of Complaint #NV00 failed to: 1. Provide enoug residents - unsubstantiated with Tags F 246 and F 2. Send a reside discharged - substantiated with Tags F 246 and F 2. Send a reside discharged - substantiated. 3. Prevent an av unsubstantiated. 4. Bathe a reside discharged - substantiated. The following reg identified: 16. 483.15(e)(1) ACC ORY DIRECTOR'S OR DROV The provide enoug the date for the provide enoug the formation of the provide enoug the form	RES FOR MEDICARE & MEDICALD SERVICES TOP DEFICIENCIES TOP DEFICIENCY TO THE TOP DEFICIENCIES TO THE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS This Statement of Deficiencies was generated as the result of a complaint investigation conducted at your facility on 9/21/06. The complaint was finalized on 10/6/06 during a follow up survey that was sent under separate cover. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil actions or other claims for relief that may be available to any party under applicable federal, state or local laws. Complaint #NV00012927 alleged that the facility failed to: 1. Provide enough staff to properly care for the residents - unsubstantiated. 2. Provide enough staff to accommodate the needs of the residents in a dining room - substantiated with federal deficiencies cited. See Tags F 246 and F 325. 2. Send a resident's personal belongings when discharged - substantiated with no federal deficiencies cited. 3. Prevent an avoidable fall in one resident - unsubstantiated. 4. Bathe a resident for five days and discharge the resident in a clean condition - unsubstantiated. The following regulatory deficiencies were identified: 1. Provide a part of the patients. (See instruction to the patients. (See instruction to the patients. (See instruction to patients.) 2. Provent an avoidable fall in one resident - unsubstantiated. The following regulatory deficiencies were identified: 3. Prevent an avoidable fall one or resident in a clean condition - unsubstantiated. The following regulatory deficiencies a deficiency were identified: 3. Provide the patient of the patients. (See instruction to the patients.) (See instruction to the patients.) (See instruction to th	RESPORMEDICARE & MEDICAID SUPPLIER (X2) MULTIL (X2) MULTIL (X2) PROVIDER SUPPLIER (X1) PROVIDER ON NUMBER: DENTIFICATION NUMBER: DEN	This Statement of Deficiencies was generated at the result of a complaint investigation conducted at your facility on 92/106. The construct of Deficiencies was generated at the result of a complaint investigation conducted at your facility on 92/106. The complaint was sprohibiting any criminal or civil actions or other claims for relief that may be available to any party under applicable federal, state or local laws. Complaint #NV00012927 alleged that the facility failed to: 1. Provide enough staff to accommodate the needs of the residents - unsubstantiated. 2. Provide enough staff to accommodate the needs of the residents in a cliniar groom-substantiated with no federal deficiencies cited. 3. Prevent an avoidable fail in one resident-unsubstantiated. 4. Bathe a resident for five days and discharge the resident in a clean condition - unsubstantiated. The following regulatory deficiencies were identified: 1. Provide enough staff to properly care for the residents - unsubstantiated with no federal deficiencies cited. 3. Prevent an avoidable fail in one resident-unsubstantiated. 4. Bathe a resident for five days and discharge the resident in a clean condition - unsubstantiated. The following regulatory deficiencies were identified: 1. Provide enough staff to properly care for the resident in a clean condition - unsubstantiated. 2. Provide enough staff to accommodate the needs of the resident in a clean condition - unsubstantiated. 3. Prevent an avoidable fail in one resident-unsubstantiated. 4. Bathe a resident for five days and discharge the resident in a clean condition - unsubstantiated. 5. Provide enough staff to properly care for the resident in a clean condition - unsubstantiated. 6. Provide enough staff to properly care for the resident in a clean condition - unsubstantiated. 7. Provide enough staff to properly care for the resident in the facility failed of the facility of t

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIAL PREFIX (EACH CORRECTIVE ACTION STRONG DATE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PREFIX TAG F 246 F 246	DEPAR1	MENT OF HEALIF	I AND HUIVIAN OLIVIOLO					<u> 1 860-956</u>
A BUILDING A BUILDING A BUILDING C C B. WING C B. WING TO/06/2006 STREET ADDRESS, CITY, STATE, ZIP CODE 201 KOONTZ LANE CARSON CITY, NV 89701 CX4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) F 246 F 246 F 246 F 246 F 246	CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	(X2) N	ULTIP	PLE CONSTRUCTION	(X3) DATE SUI	RVEY ED
NAME OF PROVIDER OR SUPPLIER EVERGREEN MOUNTAINVIEW HEALTH (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) EVERGREEN MOUNTAINVIEW HEALTH STREET ADDRESS, CITY, STATE, ZIP CODE 201 KOONTZ LANE CARSON CITY, NV 89701 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE F 246 F 246 F 246	STATEMENT	OF DEFICIENCIES	IDENTIFICATION NUMBER:	1			-	
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(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL TAG (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION AND COMPLET COMPLET DATE COMPLET DATE TAG F 246 F 246	FVFRGR	EEN MOUNTAINVIE	W HEALTH		C.			
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	PRÉFIX	I SECONDICKON	MINIST RE PRECEEDED DI FULL			CROSS-REFERENCED TO THE AF	PROPRIATE	DATE
A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review it was determined that the facility failed to accommodate the individual needs for 3 of 17 residents in the dining room of the secure unit. (Residents #1, #2, and #3) Findings include: On 9/21/06, at 8:15 AM, a general observation was made of the dining area in the secure unit on Station #2. Seventeen residents were observed in the dining room at that time. Three employees were assisting the residents eat. One of the staff members on the secure unit was interviewed. She stated that three of the residents were able to feed themselves independently. The rest of the	F 246	A resident has the services in the fact accommodations or preferences, except the individual or of endangered. This REQUIREMED by: Based on observative with was determined accommodate the residents in the diagnostic of the Station #2. Sever in the dining room were assisting the members on the She stated that the feed themselves residents needed physical assistant member stated the to three residents get the trays. She employees assist meats. She stated would assist the services in the state of the state o	right to reside and receive lity with reasonable of individual needs and pt when the health or safety of her residents would be ENT is not met as evidenced Ition, staff interview, and record rmined that the facility failed to individual needs for 3 of 17 ning room of the secure unit. It and #3) In AM, a general observation dining area in the secure unit on inteen residents were observed in at that time. Three employees is residents eat. One of the staff is secure unit was interviewed. In the residents were able to independently. The rest of the either cueing by the staff or ce with their meals. A staff inat three trays were not delivered in three trays were not delivered in the staff or independently the staff		246	Actions taken for the resident Resident #1 has been reassessed dietitian and the MD has been to of the recommendations. The lare being followed. The reside receiving her meals in a timely staff is assisting her as she will Residents #2 and #3 are being their meals as they will allow. administering the Resource nut supplement will be reviewed. How other potential resident identified: All residents needing assistance potential to be at risk. Measures/systemic changes to deficient practices do not recommend assistance. The meal passistance. The meal passistance. The meal passistents will be assisted time. How the facility will monitor actions: The Executive Director or desperform random audits weekly dining room to ensure that the	d by the made aware MD orders ant is manner and allow. assisted with The timing of tritional as are the have the to ensure occur: timing for ss times will yen timely and ly. r corrective signee will y in each a residents	ok

Event ID: X4WN11

Facility ID: NVN3331SNF

If continuation sheet Page 2 of 12

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EVERGREEN MOUNTAINVIEW HEALTH CARSON CITY, NV 89701 (X5)	DEPART	MENI OF HEVELL	A MEDICAID CEDVICES					<u> </u>
TATALEMENT OF DEPICIENCES INTO PROVIDER OR SUPPLIER EVERGREEN MOUNTAINVIEW HEALTH SUMMARY STATEMENT OF DEPICIENCES PLAN BY A STATE AND A	THE REPORT OF THE PROVIDER/SUPPLIER/CLIA			(X2) N	IULT	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER EVERGREEN MOUNTAINVIEW HEALTH SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 246 Continued From page 2 The resident's diagnoses included dysphagia, hypertension, senile dementia, iron deficiency anemia and venous insufficiency. On 9/21/05, at 8.15 AM, a breakfast meal observation was made in the dining area of the secure unit Station #2. The resident had a mechanical soft, vegetarian meal. The resident appeared to be asleep in her chair and not eating her meal. At 8.35 AM, she was awakened and asked "are you done?" The resident replied just about and started drinking her milk. A staff member came in to the dining area and asked about the resident. One of the employees assisting the resident had Resource before her meals and did not eat her meals. She stated that the resident that Resource was good enough. At 8.40 AM, the resident twas observed attempting to eat her eggs with a fork but having difficulty. At 8.45 AM, the resident twas sill attempting to eat her eggs with a fork but having difficulty. At 8.45 AM, the resident replied that she was not done yet. At 8.50 AM, she was saill working on her milk. At 9.50 AM, the resident replied, "I guess so" and her tray was taken away. There was no physical attempt made to help the resident #4. On 10/5/06, a breakfast dining observation of Resident #4 was made in the Station #2 dining room. The cart with the resident's tray arrived at 7.04 AM 41.75 AM had 1.75 AM ha	STATEMENT	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:					
NAME OF PROVIDER OR SUPPLIER EVERGREEN MOUNTAINVIEW HEALTH SUMMARY STATEMENT OF DEFICIENCIES (EACH OPERICIENCY MUST BE PRECEEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) F 246 Continued From page 2 The resident's diagnoses included dysphagia, hyperfension, senile dementia, iron deficiency anemia and venous insufficiency. On 9/21/06, at 8:15 AM, a breakfast meal observation was made in the dining area of the secure unit Station #2. The resident had a mechanical soft, vegetarian meal. The resident appeared to be asleep in her chair and not eating her meal. At 8:35 AM, she was awakened and asked "are you done?" The resident replied just about and started drinking her milk. A staff member came in to the dining area and asked about the resident. One of the employees assisting the residents across the room stated that the resident had Resource before her meals and did not eat her meals. She stated that the Resource was good enough. At 8:40 AM, the resident was still attempting to eat her eggs with a fork but having difficulty. At 8:45 AM, the resident was steed if she wanted anymore. The resident replied that she was not done yet. At 8:50 AM, she was still working on her milk. At 9:50 AM, the resident replied that she was not hypical attempt made to help the resident #4 was made in the Station #2 dining room. The cart with the resident's tray arrived at 7:40 AM. At 7:55 AM two staff members were			295079	B. WI	NG_		1	1
EVERGREEN MOUNTAINVIEW HEALTH (XA) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL FACE) FREGULATORY OR USO (DEPTIFYING INFORMATION) F 246 Continued From page 2 The resident's diagnoses included dysphagia, hypertension, senile dementia, iron deficiency anemia and venous insufficiency. On 9/21/06, at 8:15 AM, a breakfast meal observation was made in the dining area of the secure unit Station #2. The resident had a mechanical soft, vegetarian meal. The resident appeared to be asleep in her chair and not eating her meal. At 8:35 AM, she was awakened and asked "are you done?" The resident replied just about and started drinking her milk. A staff member came in to the dining area and asked about the resident. One of the employees assisting the residents across the room stated that the resident had Resource before her meals and did not eat her meals. She stated that the Resource was good enough. At 8:40 AM, the resident was still attempting to eat After she put her fork down she was asked if she wanted anymore. The resident replied that she was not done yet. At 8:50 AM, she was still working on her milk. At 9:50 AM, she was still working on her milk. At 9:50 AM, she was still working on her milk at 9:50 AM, the resident was asked, "Are you done?" The resident replied, "I guess so" and her tray was taken away. There was no physical attempt made to help the resident eat. On 10/5/06, a breakfast dining observation of Resident #1 was made in the Station #2 dining room. The cart with the resident's tray arrived at 7:40 AM. At 7:55 AM they staff members were	NAME OF PE	ROVIDER OR SUPPLIER	<u> </u>		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
(XA) ID RECOULTING THE PRECEDENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 246 Continued From page 2 The resident's diagnoses included dysphagia, hypertension, senile dementia, iron deficiency anemia and venous insufficiency. On 9/2/106, at 8:15 AM, a breakfast meal observation was made in the dining area of the secure unit Station #2. The resident had a mechanical soft, vegetarian meal. The resident appeared to be asleep in her chair and not eating her meal. At 8:35 AM, she was awakened and asked "are you done?" The resident replied just about and started drinking her milk. A staff member came in to the dining area and asked about the resident. One of the employees assisting the residents across the room stated that the resident had Resource before her meals and did not eat her meals. She stated that the Resource was good enough. At 8:40 AM, the resident was observed attempting to eat her eggs with a fork but having difficulty. At 8:45 AM, the resident was still attempting to eat her eggs with a fork but having difficulty. At 8:45 AM, the resident was still attempting to eat her eggs or and her tray was taken away. There was no thone yet. At 8:50 AM, she was still working on her milk. At 9:50 AM, the resident replied, "I guess so" and her tray was taken away. There was no physical attempt made to help the resident #4 was made in the Station #2 dining room. The cart with the resident's tray arrived at 7:40 AM. 4t 7:55 AM two staff members were	EVERGRI	EEN MOUNTAINVIEV	V HEALTH			CARSON CITY, NV 89701		0/5
The resident's diagnoses included dysphagia, hypertension, senile dementia, iron deficiency anemia and venous insufficiency. On 9/21/06, at 8:15 AM, a breakfast meal observation was made in the dining area of the secure unit Station #2. The resident had a mechanical soft, vegetarian meal. The resident appeared to be asleep in her chair and not eating her meal. At 8:35 AM, she was awakened and asked "are you done?" The resident replied just about and started drinking her milk. A staff member came in to the dining area and asked about the resident. One of the employees assisting the residents across the room stated that the resident had Resource before her meals and did not eat her meals. She stated that the Resource was good enough. At 8:40 AM, the resident was observed attempting to eat her eggs with a fork but having difficulty. At 8:45 AM, the resident was still attempting to eat. After she put her fork down she was asked if she wanted anymore. The resident replied that she was not done yet. At 8:50 AM, she was still working on her milk. At 9:50 AM, she was still working on her milk. At 9:50 AM, the resident was asked, "Are you done?" The resident replied, "I guess so" and her tray was taken away. There was no physical attempt made to help the resident #1 was made in the Station #2 dining room. The cart with the resident's tray arrived at 7:00 AM At 7:55 AM two staff members were	PRÉFIX	ACADIL DEGLOSMOV	MILET RE PRECEEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHO	OLD RF	COMPLETION
sat in front of her food without eating. A third staff member left to get a resident some sausage. At 8:15 AM, Resident #1 was observed sitting in front of her food and not eating. Her meal monitor flow sheet revealed that between 10/1/06	F 246	The resident's diag hypertension, senile anemia and venous 8:15 AM, a breakfa in the dining area of the resident had a meal. The resident chair and not eating was awakened and resident replied jusher milk. A staff marea and asked ab employees assisting room stated that the before her meals a stated that the Res 8:40 AM, the reside eat her eggs with a 8:45 AM, the reside After she put her forwanted anymore. Was not done yet, working on her mill was asked, "Are you" guess so" and he was no physical attresident eat. On 10/5/06, a break Resident #1 was more resident eat. On 10/5/06, a break Resident #1 was more resident eat. On 10/5/06, a break Resident #1 was more resident eat.	noses included dysphagia, e dementia, iron deficiency insufficiency. On 9/21/06, at st meal observation was made if the secure unit Station #2. mechanical soft, vegetarian tappeared to be asleep in her gher meal. At 8:35 AM, she asked "are you done?" The tabout and started drinking ember came in to the dining out the resident. One of the gether esidents across the eresident had Resource and did not eat her meals. She cource was good enough. At eat was observed attempting to a fork but having difficulty. At eat was still attempting to eat. One of the series was good enough. At eat was observed attempting to eat. One of the series was still attempting to eat. One of the ent was still attempting to eat. One of the series was still attempting to eat. One of the eat was still attempting to eat. One of the eat was still attempting to eat. One of the eat was still attempting to eat. One of the eat was still attempting to eat. One of the eat was still attempting to eat. One of the eat was still attempting to eat. One of the eat was still attempting to eat. One of the eat was still attempting to eat. One of the eat was asked if she the esident replied that she attempting to eat. One of the eat was taken away. There tempt made to help the eating of the esident seat while Resident #1 one of without eating. A third staff a resident some sausage. At #1 was observed sitting in the not eating. Her meal		246			

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Facility ID: NVN3331SNF

If continuation sheet Page 3 of 12



DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/18/2006 FORM APPROVED

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N	IULTIF	PLE CONSTRUCTION		OMB NO (X3) DATE S	APPROVE . 0938-039
		2022-	- 1	ILDING	· · · · · · · · · · · · · · · · · · ·		COMPLI	ETED
NAME OF P	ROVIDER OR SUPPLIER	295079	B. Wi	AG			С	
	EEN MOUNTAINVIE			STREET ADDRESS, CITY, STATE, ZIP COD				
		W HEALTH		20	1 KOONTZ LANE	ZIP CODE		
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES		C/	ARSON CITY, NV 89701			
TAG	REGULATORY OR I	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC (DENTIFYING INFORMATION)	ID	J	PROVIDER'S BLANK	\		
- 5		100 (DENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE A CROSS-REFERENCED TO	CTION SHOU	ION LD BF	(X5) COMPLETION
F 246	Continued From pa				CROSS-REFERENCED TO		PRIATE	DATE
1	had between 5 and	age 3	F	246				
- 4	the other days Sh	20 percent of her breakfast	, ,	240				
	percent of her lung	b had between 50 and 75		l				
	refused one dinner	one day was left blank, and						
	two days were reco	orded at 5 percent taken for						
	that time frame. H	er October weight was						
	in Sentember The	unds. She weighed 88 pounds						
	reviewed. There w	e resident's chart was						
	interventions since	resident's chart was ras no evidence of any further the observations made on						
- 1	9/21/06.	the observations made on						
	An observe							
	at 7:30 AM rouse	medication pass on 10/5/06						
1	administered 120 a	d that the resident was						
i	supplement instead	t of eq						
	LPN administering	the Resource stated that						
	Resident #1 had no	of Page 120 Cr's of Pag						
	was giving the patie	ent 120 cc's of Resource						
1	nufritional contact	red 60 cc." Review of the						
1	distribution was 180	% profes. The caloric						
4	and 39% fat. Resid	% protein, 43% carbohydrate, lent #1 would have been		ĺ				
	provided 120 calorie	es with the supplement twice a						
1	day if administered	as ordered.						
4	Resource 2.0 was c	ord revealed that 60 cc's of					1	
i i	pass. Resident #1	rossitud with the medication						
	her breakfast meal	with her morning medication.						
1.	The Resource was	given to the resident at 7:30		ł				
	Approximatel a	given to the resident at 7:30 /as served breakfast at						
1	found indication 44 =	AM. There was no evidence						
13	give the Resource	Awi. There was no evidence the facility had attempted to attimes not so near her						
13	breakfast meal.	not so near her					Ì	
10				Į			ļ	
M CMC oc-	and those recent qua	arterly nutritional notes signed					Ī	
W CIVIS-256	7(02-99) Previous Versions	Obsolete Event ID: X4WN11			And the second s			
		Eventio: x4WN11	Fac	lity ID:	NVN3331SNF	- BY	/ Pro-	

. TOMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL	DING G	ONSTRUCTION	10/0	C 06/2006
AME OF P	ROVIDER OR SUPPLIER	295079		201 KC	ADDRESS, CITY, STATE, ZIP COD	E	
VERGR	EEN MOUNTAINVIEV	W HEALTH		CARS	ON CITY, NV 89701 PROVIDER'S PLAN OF COR	RECTION SHOULD BE	(X5) COMPLETION
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADEFICIENCY)	PPROPRIATE	DATE
F 246	independently. It a 60 cc's of Resource it. She noted that between 5 to 30% lunch. There was record that the resource time frames of the the resident would resident would resident was reviewed dietician. There was approaches to industry attempted to solve Cross reference The dietician state	was able to feed herself also revealed that she was on the twice a day and took 100% of the resident's food intake was for breakfast and 10 to 20% for no evidence found in the ident's ability to feed herself or that an attempt to alter the Resource was made to see if eat more of her meals. The plan for Resident #1 revealed and on 8/21/06 by the registered were no dates next to the icate new interventions were the the recent weight loss issue. Tag F 325. The details the the proportion of the twas receiving double the recent was receiving double the recent was to make the appropriate dietary.	F 2	246			
	Resident #2: The 3/14/03. The resibladder disorder, and osteoporosis breakfast meal of secured unit dinir resident was obscereal and applemouth. She then with her fingers sat in front of her spoon and had a	e resident was admitted on ident's diagnoses included dementia, esophageal reflux, On 9/21/06, at 8:15 AM, a diservation was made in the englarea on Station #2. The erved attempting to drink her hot sauce but nothing went into her resorted to eating some eggs. She then stopped and her food At 8:35 AM, she found her few spoonfuls of eggs. When id no one helped redirect the tensils so that she could eat her			To the state of th		

Event ID: X4WN11

Facility ID NVN3331SNF



T/Y2) MILLIPLE CONSTRUCTION	(X3) DATE SURVEY	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIERCEIA	COMPLETED	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	С	
295079 B. WING	10/06/2006	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 201 KOONTZ LANE		
EVERGREEN MOUNTAINVIEW HEALTH CARSON CITY, NV 89701	ION (X5)	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY)	LD BE OOM TELL	
F 246 Continued From page 5 taken away approximately 75% of her food remained on her plate. She did finish her milk. Review of the dietician's nutritional notes, dated 977/06, revealed that Resident #2 was able to feed herself with a one person assist. During the observed meal time there was no one who physically assisted Resident #1 with her meal or redirected her to use her utensils when she attempted to drink her hot cereal and applesauce but was unable to do so. Resident #3: The resident was admitted on 177/05. The resident's diagnoses included profound mental retardation, convulsions, and cerebral palsy. On 9/21/06, at 8:15 AM, a breakfast meal observation was made in the secured unit dining area on Station #2. The resident's diet order revealed that he was on a pureed drinkable honey thick diet. He was observed eating his meal with his fingers. His face was full of food as well as his chest area, and there was orange colored liquid spilled on the floor near him. A staff member stated that he got mad when staff tried to help him eat. She also stated that he had not spilled food all over the floor like he normally does. Based on this information it would be difficult to obtain accurate measurements of the resident's food intake. A review of the record revealed that on 12/30/05 Resident #3 was able to eat a cup of food with a spoon. After that time there were notes that the resident's toy himself but there was no indication on how he was eating his food. There was no recent evaluation by occupational therapy to see if he was still able to eat with a spoon.		

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DEPART	MENT OF HEALTH	I AND HUMAN SERVICES & MEDICAID SERVICES					APPROVED 0938-0391
TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	.IA (X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED C 10/06/2006	
	295079			IG			
	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE 1 KOONTZ LANE		
EVERGR	EEN MOUNTAINVIE	N HEALTH		Ç/	ARSON CITY, NV 89701		
(X4) ID PREFIX TAG	/EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 246	On 9/21/06, at app speech therapist with the Resident #3 with the Resident #3 with the would be able to documented that his 12/30/05. She start had not been condispeak with the resident observed other residents observed other residents sitt their lunches. On 9/21/06, at app trays were also observed other residents sitt their lunches. On 9/21/06, at app above was discuss (DON) and the addithe reason not allow their trays in a time staff member in traying difficulty may being addressed. The individual observed discussed with the resident's	roximately 10:40 AM, the ras interviewed. She stated as unable to advance to finger sked if occupational therapy at a recent evaluation to see if o use utensils since it was a ble to use a spoon on ted that a current evaluation ucted and that she would ident's nurse about obtaining	F2	246			

were instructed to help residents eat along with the nurse aides. During the meal observation the nurse assigned to the locked unit was busy

administering medications to the residents. After the initiation of the meal observation the staff

development nurse later came in to help.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 10/06/2006	
AND PLAN C	F CORRECTION		A. BU	ILDING NG			
		295079				10/06	5/2006
	ROVIDER OR SUPPLIER EEN MOUNTAINVIE	W HEALTH		20	EET ADDRESS, CITY, STATE, ZIP CODE 11 KOONTZ LANE ARSON CITY, NV 89701		
(X4) ID PREFIX TAG	(FACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 246	Continued From pa	age 7	F	246			
F 325 SS=D	the Station #2 dinir were assisting 22 rarrived at 7:10 AM trays from this cart different tables and watched them. Or that a new staff me because she was was supposed to vreceived their trays first cart. A second AM. The three tray for half an hour weresidents. At 7:55 assisting residents residents that requivith their food in freceived their tray had come the first cart arriver resident was assishad passed. 483.25(i)(1) NUTR Based on a resident status, selvels, unless the redemonstrates that This REQUIREME by: Based on record residents.	eral observation was made of a groom. Three staff members esidents. The first meal cart. Two residents were given. They were each sitting at deating while their table mates are of the staff members stated ember had passed out the trays new and was unaware that she wait until all the resident. Three trays were left on the dicart of trays arrived at 7:40 ys that had been sitting around re then distributed to the AM two staff members were with their meals. Four other ired assistance were waiting ont of them. At 8:15 AM, the ing assistance was assisted; off the first cart. From the time diat 7:10 AM to the time the last ted with her food 55 minutes. ITION In this comprehensive acceptable parameters of such as body weight and protein resident's clinical condition this is not possible. INT is not met as evidenced eview and observation it was a facility failed to monitor,	F	325	F325 Actions taken for the residents of Resident #1 had a significant weigh between her readmission in Nover and February 2006. Since then she stabilized and gained some weight indicated by the history in the defit The care plan has been updated to current needs. How other potential residents an identified: All residents needing assistance, we dementia, residents needing assist sudden illness have the potential traffected.	th loss nber 2005 e has t as iciency. reflect her re	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	IULTIP ILDING	PLE CONSTRUCTION 3	COMPLETED	
		295079	B. WII	NG		10/06/2006	
	ROVIDER OR SUPPLIER						
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 325	re-evaluate and presidents. (Resident #1: The facility on 5/8/03 at The resident's diathypertension, sent anemia and venous 15 AM, a breakfin the dining area The resident had a meal. The resident had a meal. The resident replied juther milk. A staffin area and asked at employees assisting room stated that the before her meals stated that the Resident reggs with 8:45 AM, the resident her eggs with 8:45 AM, the resident her eggs with 8:45 AM, the resident her her wanted anymore. Was not done yet working on her mid was asked, "Are yill guess so" and had was no physical a resident eat. On 10/5/06, a bre Resident #1 was no The cart wa	revent weight loss for 1 of 17	F	325	Measures/systemic changes to edeficient practices do not reocci. The staff will be educated on diet and care plan updates. This will in new information discovered with resource protocol. Residents with loss will be reassessed by the diet. How the facility will monitor coactions: The facility will conduct a weekly to review residents that have had loss. The care plans will be revier revised at this meeting. The result meetings will be reviewed by the QI meetings.	ary needs include any the n weight itian. rrective y meeting weight iwed and lts of these	11-4-8

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIER/CLIA	1		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
IND PLAN C	OOMEONON		A. BUILDING B. WING			C 10/06/2006		
	ROVIDER OR SUPPLIER	295079 V HEALTH		2	REET ADDRESS, CITY, STATE, ZIP CODE 201 KOONTZ LANE CARSON CITY, NV 89701	10,00	72000	
(X4) ID PREFIX TAG	(FACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 325	sat in front of her formember left to get 8:15 AM, Resident front of her food an monitor flow sheet and 10/5/06 she had between 5 and the other days. Ship percent of her luncher fused one dinner two days were recorded as 85 pour in September 2006 reviewed. There winterventions since 9/21/06.	esidents eat while Resident #1 bod without eating. A third staff a resident some sausage. At #1 was observed sitting in d not eating. Her meal revealed that between 10/1/06 id refused breakfast twice, and 20 percent of her breakfast e had between 50 and 75 in between those days. She is one day was left blank, and orded at 5 percent taken for er October 2006 weight was unds. She weighed 88 pounds. The resident's chart was as no evidence of any further the observations made on	F:	3325				
	was ordered with the #1 received the Remeal. There was rethat the facility had Resource at times. The Resource was AM. The resident was proximately 7:40. An observation of a at 7:30 AM reveale administered 120 c supplement instead LPN administering. Resident #1 had no was giving the patienstead of the ordenutritional content.	ord revealed that Resource he medication pass. Resident source before her breakfast to evidence found to indicate attempted to give the other than before breakfast. given to the resident at 7:30 was served breakfast at AM. If medication pass on 10/5/06 d that Resident #1 was ic's (240 calories) of the dof 60 cc's as ordered. The the Resource stated that bet been eating well so the staff ent 120 cc's of Resource red 60 cc's." Review of the of Resource 2.0 revealed that it it is per cc. The caloric						

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FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING С B. WING 10/06/2006 295079 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 201 KOONTZ LANE **EVERGREEN MOUNTAINVIEW HEALTH** CARSON CITY, NV 89701 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES 1D (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) F 325 Continued From page 10 F 325 distribution was 18% protein, 43% carbohydrate, and 39% fat. Resident #1 would have been provided 120 calories with the supplement twice a day if administered as ordered. The most recent quarterly nutritional notes signed by the registered dietician on 8/21/06, revealed that Resident #1 was able to independently feed herself. It also revealed that she was on the Resource twice a day and took 100% of it. She noted that the resident's food intake was 25% for breakfast, lunch and dinner. There was no evidence found in the record that the resident's ability to feed herself was reevaluated or that an attempt to alter the time frames of the Resource was made to see if the resident would eat more of her meals. A review of the weight record revealed that Resident #1's weight history was: 100 pounds on 11/11/05 92 pounds on 12/1/05 90 pounds on 1/4/06 83 pounds on 2/1/06 85 pounds on 3/3/06 84 pounds on 4/4/06 87 pounds on 8/7/06 88 pounds on 9/6/06. 85 pounds in October 2006

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loss issue.

The alteration in nutrition care plan was dated 11/15/05. Although the careplan was reviewed on 8/21/06 by the registered dietician there were no dates next to the approaches showing that new interventions were attempted to solve the weight

The dietician stated that no one had reported to

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-0391		
STATEME'N'	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
	295079			NG_			/2006	
NAME OF P	NAME OF PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
EVERGREEN MOUNTAINVIEW HEALTH					CARSON CITY, NV 89701			
(X4) ID PREFIX TAG	(FACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 325	Continued From pa	ge 11 t was receiving double the o make the appropriate dietary	F	325	 			
						•		

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